Montana State Loan Repayment Program (MT SLRP)
Provider Application: New and Continuing
10/1/2014

Provider Type: Check One

Primary Care
___Physician (MD/DO) ___ Nurse Practitioner ___Certified Nurse Midwife
___Physician Assistant ___Registered Nurse

Approved Primary Care Specialties for Physicians
___ Internal Medicine ___ Pediatrics ___ Obstertrics/Gynecology
___Geriatrics ___ Psychiatry ___ Family Medicine (Osteopathic General Practice)

Approved Primary Care Specialties for Nurse Practitioners & Physician Assistants
___ Adult ___ Family ___ Pediatrics
___Psychiatry/mental health ___Geriatrics ___Women's health

Mental Health
___Psychiatrist (MD/DO) ___Clinical or Counseling Psychologist ___Licensed Clinical Social Worker
___Psychiatric Nurse Specialist ___Licensed Professional Counselor ___Marriage and Family Therapist

Dental
___Dentist (DDS/DMD) ___ Registered Dental Hygienist

___ Pharmacist

Section I: Personal Information

Name: _____
(Last) (First) (Middle Initial)
Address: _____
(Number) (Street) (Apartment/Suite Number)
_____
(City) (State/Province) (Country) (Zip Code)
Telephone: _____
Home: Work:
Email: _____Fax:_____ Social Security Number: _____

Place of Birth:_____
(City) (State/Province) (Country)

Which race best describes you? (Please choose only one.)
____ American Indian or Alaska Native
____ Asian
____ Black or African American
____ Native Hawaiian/ Pacific Islander
____ White/Caucasian
____ Other (please specify) _____

Which ethnicity best describes you? (Please choose only one.)
____ Hispanic/ Latino
____ Non-Hispanic/ Latino
____ Other (please specify) _____

Indicate your MT SLRP Application Status (Check One)
___I am a new applicant ___I am a second year applicant
___I am a continuing SLRP applicant, requesting a third year of funding

Current Montana MT SLRP awardees applying for a second or third year of funding **or** if you have previously had a service obligation with MT SLRP must complete this section.

_____I certify that I have completed my initial service obligation at:

Name of Institution:_____

Complete address:_____

Contact person:_____

_____I certify that I have qualifying educational loans as indicated on the Loan Information and Verification form.

Section II: Participant Requirements

1. Are you a citizen or naturalized citizen of the United States? Yes __ No __
   NOTE: A copy of your birth certificate must be submitted with this application.

2. Are you fluent in any language other than English? Yes __ No __
   If **Yes**, please specify:_____

3. How many years of service are you willing to commit in return for loan repayment assistance?
   2 years_____ 3 years _____

4. How many hours per week will you practice in return for loan repayment assistance? _____
   (Full-time service is defined in the NHSC statute as a minimum of 40 hours per week, for a minimum 45 weeks per year. **Half-time** service is defined in the NHSC statute as a minimum of 20 hours per week (not to exceed 39 hours per week) for a minimum 45 weeks per year).

5. SLRP awardees **must not** have an outstanding contractual obligation for health professional service to the Federal Government, or to a State or other entity, unless that service obligation will be completely satisfied before the SLRP contract has been signed. Please note that certain provisions in employment contracts can create a service obligation (e.g., an employer offers a physician a recruitment bonus in return for the physician's agreement to work at that facility for a certain period of time or pay back the bonus).

   Do you have any outstanding contractual obligation for health professional services to the Federal Government to a state or other entity (including active military obligation, NHSC Scholarship or Loan Repayment, Nursing Education Loan Repayment, Nursing Scholarship or Faculty Loan Repayment programs) OR other program? Yes __ No __ If Yes,

   Name of Program:_____

   Complete Address: _____

   _____

   Contract Entity: _____

   Telephone Number: _____

   Terms of obligation: _____

Section III: Education

Undergraduate Education
Name of Institution:_____

Complete Address:_____

Dates of Attendance:_____
Start: Month/Year Graduation: Month/Year

Degree(s) Obtained:_____

Health Professional Education (provide transcripts)
Name of Institution:_____

Complete Address:_____

Dates of Attendance:_____
Start: Month/Year Graduation: Month/Year

Degree(s) Obtained: _____

Name of Training Program Director:_____

Internship/Preceptorship
Name of Institution: _____

Complete Address: _____

Dates of Attendance: _____
Start: Month/Year Graduation: Month/Year

Name of Supervising Professional: _____

Contact Information: _____
Phone email

Section IV: Professional Experience

List states in which you currently hold, or have held, a license to practice. (***Note: You must be eligible to practice in the State of Montana – please include copy of license or application for licensure with application.***)

State	License Type	Dates Licensed	License Number

Have you ever been subject to any disciplinary action or licensure restrictions? Yes __No __

If Yes, please explain: _____

Provide the name and contact information of the director or official of each site where you have practiced since completing your health professional training (Copy page as needed)

Name:_____Title:_____

Address:_____
(Complete Site Name and Address)

Telephone _____ E-mail_____
Begin Date: _____End Date:_____
Total Hours per week: _____

Client Care Hours per week: _____
Administration Hours per week : _____
Other (Specify) : _____

Name:_____Title:_____

Address:_____
(Complete Site Name and Address)

Telephone _____ E-mail_____
Begin Date: _____End Date:_____

Total Hours per week: _____

Client Care Hours per week: _____
Administration Hours per week : _____
Other (Specify) : _____

Name:_____Title:_____

Address:_____
(Complete Site Name and Address)

Telephone _____ E-mail_____
Begin Date: _____End Date:_____

Total Hours per week: _____

Client Care Hours per week: _____
Administration Hours per week : _____
Other (Specify) : _____

Section V: Professional References
Please provide names and addresses of **THREE (3)** professionals you have worked with or reported to:

1. Reference Name: _____

   Relationship to Applicant:_____

   Telephone Number: _____E-Mail Address:_____

2. Reference Name: _____

   Relationship to Applicant:_____

   Telephone Number: _____E-Mail Address:_____

3. Reference Name: _____

   Relationship to Applicant:_____

   Telephone Number: _____E-Mail Address:_____

Section VI: Personal References
Please give the names and addresses of **THREE (3)** persons, not related to you by blood or marriage, who are qualified to give information regarding your character or financial need.

1. Reference Name: _____

   Relationship to Applicant:_____

   Telephone Number: _____E-Mail Address:_____

2. Reference Name: _____

   Relationship to Applicant:_____

   Telephone Number: _____E-Mail Address:_____

3. Reference Name: _____

   Relationship to Applicant:_____

   Telephone Number: _____E-Mail Address:_____

Section VII Educational Indebtedness

Please complete Loan Information/Verification Form for each Lending Institution

Name of Lending Institution	Mailing Address	Phone Number	Account Number	Balance of Account

Section VIII: Practice Preferences

1. What date will you be available to begin practice under the MT SLRP? _____
   Month/Day/Year
2. Do you have an agreement with a designated practice site in Montana?

   Yes ____ No ____ (If yes, give location name and contact information)

   Practice Site Name: _____
   Practice Site Address: _____
   Facility CEO or Contact Name: _____
   Telephone: _____ E-mail Address:_____
   HPSA score _____
   HSPA ID _____

3. To the best of your knowledge, is this practice site, a qualified National Health Service Corps practice site? _____ Yes _____ No
4. If you do not have an agreement, please describe preference of practice location in Montana (i.e. Type of practice, distance from a hospital, size of community, preferred area in Montana, etc.) Attach page as needed.
5. Do you have a judgment lien against property to the United States? ___ Yes ___ No
   If Yes, explain _____
6. Do you have a history of failure to comply with service obligations, including
   a. Default on federal payment obligations _____ Yes _____ No

b. Breach of prior service obligations to a federal/state or local entity?___ Yes ___ No

7. Attach a one page summary of the characteristics you possess that would make you a good candidate to receive loan repayment for an underserved population practice in Montana.

Section IX: How did you hear about MT SLRP?
Please check all that apply:

_____MT PCO _____ AHEC _____Website: Name _____
_____HRSA _____Job fair: What was the name of the job fair? _____
_____Presentation: Where was the presentation? _____
_____Other: Please Describe: _____

Section IX: Service Obligations: If I receive loan repayment through the MT SLRP:

I understand: (Initial all)

1. _____ I must practice in a practice site located in a federally designated HPSA
2. _____ I must post and honor a sliding fee scale for services
3. _____ I must accept Medicaid, Medicare and SCHIP clients
4. _____ I must practice in a HPSA that corresponds to my training and /or discipline

5. _____ The practice site charges for professional services are at the usual and customary prevailing rate.
6. _____ The practice site provides services to any individual seeking care, posts and honors a sliding fee scale for services to individuals with limited incomes as per HHS Poverty Guidelines. For information about HHS Poverty Guidelines, please visit http://aspe.hhs.gov/poverty/13poverty.cfm.
7. _____ I do not have a current default on any Federal payment obligations (e.g., Health Education Assistance Loans, Nursing Student Loans, Federal income tax liabilities, Federal Housing Authority loans, etc.) even if the creditor now considers them to be in good standing.
8. _____ I do not have a breached a prior service obligation to the Federal/State/local government or other entity, even if they subsequently satisfied the obligation; and
9. _____ I do not have any Federal or non-Federal debt written off as uncollectible or received a waiver of any Federal service or payment obligation.

10. _____ I do not have any outstanding contractual obligation for health professional service to the Federal Government (e.g., an active duty military obligation, an NHSC Scholarship or Loan Repayment Program obligation, or a Nurse Corps Loan Repayment Program obligation), a State (e.g., an obligation under a State loan repayment program other than the one receiving HRSA grant funds), or other entity.

CERTIFICATION

I certify that the information I have provided in this application is accurate and complete to the best of my knowledge and belief. I understand my responses may be investigated and any willfully false representation is sufficient cause for rejection of this application. If Montana State Loan Repayment funds have been awarded, I will be required to repay the funds per the Breach of Service Provision in the Montana State Loan Repayment Program contract.

_____ _____
Signature: Date:

LOAN INFORMATION AND VERIFICATION FORM

MONTANA STATE LOAN REPAYMENT PROGRAM

Montana Primary Care Office
1400 Broadway, PO Box 202951
Helena, MT 59620-2951
406-444-3934

The following information must be provided for each individual loan submitted as part of the provider application for MONTANA's STATE LOAN REPAYMENT PROGRAM. Print clearly and completely. Once the lending institution has completed their section of the form, please attach a current statement of account to the completed forms and submit with your application materials.

APPLICANT: Please complete one copy of this form for each loan you are including on your MT SLRP application. Please print clearly and be sure to complete all of requested information. UPON COMPLETION OF PART A, SEND THIS FORM TO YOUR LENDER TO COMPLETE THE VERIFICATION CONTAINED UNDER PART B and have them return the completed form back to you—SUBMIT BOTH COMPLETED FORMS (PART A AND PART B) WITH YOUR APPLICATION MATERIALS TO Montana Primary Care Office at the address indicated above.

LENDING INSTITUTION: PLEASE COMPLETE PART B OF THIS FORM AND RETURN TO THE APPLICANT TO BE SUBMITTED WITH THEIR APPLICATION MATERIALS.

PART A - *(To be completed by Applicant)*

1. NAME: (Last, First, Middle) 2. BIRTHDATE: 3. SOCIAL SECURITY NUMBER:

4. COMPLETE ADDRESS: (Street, P O Box, City, State, Zip) 5. TELEPHONE NUMBER:

6. NAME OF LENDING INSTITUTION:

7. TELEPHONE NUMBER:

8. FAX NUMBER:

9. LOAN ACCOUNT NUMBER:

10. FULL ADDRESS OF LENDING INSTITUTION: (Street, P O Box, City, State, Zip)

11. LOAN INFORMATION:
Loan Account Number: _____ Original Date of Loan: _____
Original Amount of Loan: _____ Current Balance/Date: _____

12. PURPOSE OF LOAN AS INDICATED ON LOAN APPLICATION:

13. TYPE OF LOAN: ☐ Federal Family Education Loan ☐ Federal Direct Loan
☐ Federal Family Education Consolidation Loan ☐ Federal Direct Consolidation Loan
☐ Federal Perkins Loan

FOR CONSOLIDATED UNDERGRADUATE AND GRADUATE EDUCATION LOANS:
If you have consolidated your loans for undergraduate and graduate education costs, you must attach documentation outlining the individual loan numbers, loan dates and loan amounts that were consolidated into the new loan.

WARNING:
Any person, who knowingly makes a false statement or misrepresentation in this loan repayment transaction, fraudulently obtains repayment for a loan, or commits any other illegal action in connection with this transaction is subject to repaying any amount received from this program plus 8% interest. I have read this statement and understand its contents.

CERTIFICATION AND ACCOUNT AUTHORIZATION BY APPLICANT:
I hereby certify to the accuracy of the above information and apply to enter into an agreement with the MT Department of Public Health and Human Services for repayment towards the education loans I have submitted with my application hereof. These loans were incurred solely for the costs of education. I hereby authorize the financial institution named in Item 5 above to release all applicable loan information to Montana Primary Care Office as necessary.

_____ _____
SIGNATURE OF APPLICANT DATE

LOAN INFORMATION AND VERIFICATION FORM
THE MONTANA STATE LOAN REPAYMENT PROGRAM

PART B - ***(To be completed by Lending Institution)***

The individual identified on the first page of this form has applied to participate in the Montana State Loan Repayment Program and states that, to the best of his/her knowledge, the loan information provided is a bona fide legally enforceable government educational loan made for the purpose of meeting the borrower's educational costs. Please verify this information according to your records by completing the information below.

ACCOUNT NUMBER:_____

ORIGINAL AMOUNT OF LOAN:_____
(If this is a consolidation, please provide detail regarding the original loan amounts for all loans consolidated.)

ORIGINAL DATE OF LOAN:_____
(If this is a consolidation, please provide detail regarding the original loan dates for all loans consolidated.)

CURRENT LOAN BALANCE:_____
(Balance) (Date)

LENDING INSTITUTION/LOAN SERVICER: _____
(Name)

_____
(Street Address)

_____
(City, State, Zip Code)

_____
(Telephone) (FAX)

_____
(Federal Tax ID Number)
(Required for Payment Processing)

PERSON TO CONTACT REGARDING CURRENT LOAN BALANCE INFORMATION:

_____
(Name)

_____
(Department)

_____
(Telephone)

COMMENTS:

I hereby certify to the accuracy of the loan information contained on the reverse side of this form or as provided by the above notations and comments. If the SLRP applicant is selected for loan repayment assistance, I agree to submit a W-9 form to the MT Department of Public Health and Human Services, MT Primary Care Office.

_____
SIGNATURE

_____
TITLE

_____
DATE